Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

Facility Name: _____ Fax No.: _____

Facility Address: _____ Tel No: _____

The information you may release subject to this signed release form is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes
□ Care Plan	□ Lab Reports	□ Radiology Reports
□ Pathology Reports	□ Treatment Record	□ Operative Reports
□ Hospital Reports	□ Medication Record	□ Other (please specify)

Release my protected health information to the following entity:

CSSI (California Sports and Spine Institute, PC

Providers: □ **Maxim Moradian, MD** □ **Revik Vartanian, DO**

Address: 317 S. Brand Blvd., Suite , A-104 Glendale, CA 91204

51 N. 5th Ave, Suite 301, Arcadia, CA 91006

Tel: (818) 338-6860 & (626) 460-1096; Fax: (888) 425-9079

Email: medicalrecords@californiasportsandspine.com

_____ _____

Patient Name Signature of Patient or Personal representative

_____ _____

Patient Date of Birth or SSN Printed Name or patient or Personal representative

_____ _____

Date Description of Personal Representative's Authority